Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor Name and Address: DOLLY VINSANT MEMORIAL HOSPITAL 302 KINGS HWY SUITE 112 BROWNSVILLE TX 78521	MFDR Tracking #: M4-05-6783-01
	DWC Claim #:
	Injured Employee:
Respondent Name and Box #: LIBERTY MUTUAL INSURANCE CO Box #: 28	Date of Injury:
	Employer Name:
	Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Our position is that the billing in dispute has not been paid at a fair and reasonable rate in accordance with TWCC guidelines, policies, rules, and the Texas Labor Code. The TWCC has not assigned Maximum Allowable Rates for the services the subject of this claim. Furthermore, TWCC Rule 134.401(a)(4) specifically states Ambulatory/Outpatient surgical care, is not covered by the Acute Care Inpatient Hospital Fee Guidelines. It further states that such fees shall be reimbursed at a fair and reasonable rate until the issuance of a fee guideline addressing these specific types of reimbursement. In MDR: M4-04-1813-01, the Division ruled that evidence of redacted copies of payments made by the other carriers for similar treatment in the same geographical area was a proper method to determine the fair and reasonable rates."

Amount in Dispute: $6,122.14

PART III: RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The provider was reimbursed per the Texas Fee Schedule @ fair & reasonable 1118.00 X 1 = 1118.00 + interest 29.86 = $1147.86 (Total amt paid) Liberty Mutual believes the rate established by TWCC 1118.00 is F&R. It is not fair & reasonable for a provider to bill more for an outpatient surgery <2hr than an inpatient surgical day >23 hrs."

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Denial Code(s)	Disputed Service	Amount in Dispute	Amount Due
6/28/2004	A, X170, M, Z585, Z989	Hospital Outpatient Services	$6,122.14	$3,346.14
			Total Due:	$3,346.14

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code § 413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division rule at 28 Texas Administrative Code §134.1, titled *Medical Reimbursement*, effective May 2, 2006 set out the reimbursement guidelines.

This request for medical fee dispute resolution was received by the Division on April 22, 2005. Pursuant to Division rule at 28 TAC §133.307(g)(3), effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, the Division notified the requestor on May 5, 2005 to send additional documentation relevant to the fee dispute as set forth in the rule.

1. For the services involved in this dispute, the respondent reduced or denied payment with reason codes:
   - A, X170-Pre-authorization was required, but not requested for this service per TWCC Rule 134.600.
   - M, Z585-The charge for this procedure exceeds fair and reasonable.
   - Z989-The amount paid previously was less than is due. The current recommended amount is the result of supplemental payment.

2. Division rule at 28 TAC §134.600(h)(2), effective March 14, 2004, 29 TexReg 2360, states "Non-emergency health care

requiring preauthorization includes: (2) outpatient surgical or ambulatory surgical services as defined in subsection (a) of this section." The respondent initially denied reimbursement for the outpatient surgical services based upon EOB denial reason code "A" and "X170". Review of the documentation submitted by the requestor finds that on June 16, 2004, preauthorization was obtained for "Injection, anesthetic/steroid; epidural; lumbar/sacral, singl"; therefore, preauthorization was obtained as required in Division rule at 28 TAC §134.600(h)(2). This denial reason is not supported. These services will be reviewed per applicable Division rules and fee guidelines.

3. This dispute relates to outpatient surgical services provided in a hospital setting with reimbursement subject to the provisions of Division rule at 28 TAC §134.1, effective May 2, 2006, 31 TexReg 3561, which requires that, in the absence of an applicable fee guideline, reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with subsection §134.1(d) which states that "Fair and reasonable reimbursement: (1) is consistent with the criteria of Labor Code §413.011; (2) ensures that similar procedures provided in similar circumstances receive similar reimbursement; and (3) is based on nationally recognized published studies, published Division medical dispute decisions, and values assigned for services involving similar work and resource commitments, if available."

4. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.

5. Division rule at 28 TAC §133.307(g)(3)(C)(iv), effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to send additional documentation relevant to the fee dispute including a statement of the disputed issue(s) that shall include "how the submitted documentation supports the requestor position for each disputed fee issue." Review of the submitted documentation finds that the requestor did not state how the submitted documentation supports the requestor's position for each disputed fee issue. The Division concludes that the requestor has not met the requirements of Division rule at 28 TAC §133.307(g)(3)(C)(iv).

6. Division rule at 28 TAC §133.307(g)(3)(D), effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement." Review of the submitted documentation finds that:

   - The requestor asks to be reimbursed the full amount of the billed charges in support of which the requestor states "Our position is that the billing in dispute has not been paid at a fair and reasonable rate in accordance with TWCC guidelines, policies, rules, and the Texas Labor Code. The TWCC has not assigned Maximum Allowable Rates for the services the subject of this claim. Furthermore, TWCC Rule 134.401(a)(4) specifically states Ambulatory/Outpatient surgical care, is not covered by the Acute Care Inpatient Hospital Fee Guidelines. It further states that such fees shall be reimbursed at a fair and reasonable rate until the issuance of a fee guideline addressing these specific types of reimbursement. In MDR: M4-04-1813-01, the Division ruled that evidence of redacted copies of payments made by the other carriers for similar treatment in the same geographical area was a proper method to determine the fair and reasonable rates."
   - The requestor does not discuss or explain how additional payment of $6,122.14 would result in a fair and reasonable reimbursement.
   - In support of the requested reimbursement, the requestor submitted redacted EOBs for services that are similar to the services in dispute. However, the requestor did not discuss or explain how the sample EOBs support the requestor's position that additional payment is due. The reimbursement methodology is not described on the EOBs. Nor did the requestor explain or discuss the sample carriers' methodologies or how the payment amount was determined for each sample EOB. The requestor did not discuss or provide documentation to support whether such payment, as reflected in the sample EOBs, was typical for the services in dispute.
   - The requestor does not discuss or explain how payment of the requested amount would satisfy the requirements of Division rule at 28 TAC §134.1.
   - The Division has previously found that a reimbursement methodology based upon payment of a hospital's billed charges, or a percentage of billed charges, does not produce an acceptable payment amount. This methodology was considered and rejected by the Division in the *Acute Care Inpatient Hospital Fee Guideline* adoption preamble which states at 22 Texas Register 6276 (July 4, 1997) that:

     "A discount from billed charges was another method of reimbursement which was considered. Again, this method was found unacceptable because it leaves the ultimate reimbursement in the control of the hospital, thus defeating the statutory objective of effective cost control and the statutory standard not to pay more than for similar treatment of an injured individual of an equivalent standard of living. It also provides no incentive to contain medical costs, would be administratively burdensome for the Commission and system participants, and would require additional Commission resources."

7. The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by

the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307(g)(3)(C), and §133.307(g)(3)(D). The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is $0.00.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code §413.011(a-d), §413.031 and §413.0311
28 Texas Administrative Code §133.307, §134.1, §134.600
Texas Government Code, Chapter 2001, Subchapter G

PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is not entitled to additional reimbursement for the services involved in this dispute

DECISION:

		12/07/2010
Authorized Signature	Medical Fee Dispute Resolution Officer	Date

PART VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 TAC §148.3(c).

Under Texas Labor Code §413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code §413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.